LOS ANGELES COUNTY COMMISSION ON HIV

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While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV
ANNUAL MEETING MINUTES
November 12, 2009

MEMBERS PRESENT	MEMBERS PRESENT	PUBLIC, CONT.	OAPP/HIV EPI STAFF
Carla Bailey, *Co-Chair*	Jennifer Sayles	Shawn Griffin	Kyle Baker
Anthony Braswell, *Co-Chair*	Stephen Simon	Marc Haupert	Michael Green
Everett Alexander	Robert Sotomayor	Tonya Hendricks	Joanne Oliver
Sergio Aviña	Kathy Watt	Miki Jackson	Carlos Vega-Matos
Al Ballesteros	Fariba Younai	Thelma James	Juhua Wu
Carrie Broadus		David Kelly	Amy Wohl
Robert Butler		AJ King	
Fredy Ceja	**MEMBERS ABSENT**	Christina King	
James Chud	Eric Daar	Shelley McKittrick	**COMMISSION STAFF/CONSULTANTS**
Nettie DeAugustine	Lee Kochems	Carol Magee	
Whitney Engeran-Cordova	Chris Villa	Ingrid Marchus	Julie Cross
Douglas Frye		Victor Martinez	Carolyn Echols-Watson
David Giugni		Leland Morris	Dawn McClendon
Terry Goddard	**PUBLIC**	Melissa Nuestro	Jane Nachazel
Jeffrey Goodman	Pamela Chiang	Jose Paredes	Glenda Pinney
Michael Johnson	David Crain	Vicky Pulatian	Doris Reed
Bradley Land	Camila Crespo	Steven Reigns	James Stewart
Ted Liso	Phil Curtis	Nicholas Rocca	Craig Vincent-Jones
Anna Long	Mark Davis	Tania Rodriguez	Nicole Werner
Quentin O'Brien	Thanh Doan	Julian Sanchez	Donna Yutzy
Jenny O'Malley	Miguel Fernandez	Natalie Sanchez	
Everardo Orozco	Maxine Franklin	Elana Stone	
Dean Page	Susan Forrest	Silvia Valerio	
Angélica Palmeros	Aaron Fox	Jay Villarreal	
Mario Pérez	Fanny Garcia	Sharon White	
Karen Peterson	Mark Gonzalez	Jason Wise	

1. **REGISTRATION/WELCOME**: Mr. Braswell welcomed all. He noted one-third of Commissioners are new.

2. **CALL TO ORDER**: Mr. Braswell called the meeting to order at 9:05 am.
   - **A. Roll Call (Present)/Introductions**: Alexander, Aviña, Bailey, Ballesteros, Braswell, Broadus, Butler, Ceja, Chud, DeAugustine, Engeran-Cordova, Frye, Giugni, Goddard, Goodman, Johnson, Land, Liso, Long, Orozco, Page, Palmeros, Pérez, Peterson, Sayles, Simon, Watt, Younai
     - Teresa Ayms, State Office of AIDS (OA), participated by conference call on behalf of Clarissa Poole-Sims.
     - All attendees introduced themselves and identified their affiliations.

3. **APPROVAL OF AGENDA**:
MOTION 1: Approve the Agenda Order ***(Passed by Consensus)***.

4. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED**:
   - Congratulations were offered to Mr. Ballesteros and JWCH on the opening of Community Health in downtown Los Angeles.
   - Ms. Broadus commemorated Howard Jacobs' passing, noting that she had worked with both Mark Etzel and Howard Jacobs in APLA's Public Policy Division, and now both are gone. Mr. Etzel was key in ushering in the County's Medi-Cal Managed Care HMO. Mr. Jacobs worked tirelessly to improve housing. Mr. Land added Mr. Jacobs emphasized a critical skill – working together despite disagreements. Mr. Griffin noted that both Mr. Etzel and Mr. Jacobs went way beyond their own communities to strongly support PWH of color.
   - Mr. Land also spoke of Bradford Bowen—who also passed recently—noting that he consistently supported the community by attending rallies and offering assistance whenever he could.
   - ➲ Dedicate meeting in memory and honor of Mr. Bowen, Mr. Etzel and Mr. Jacobs. A minute of silence was observed.

6. **REVIEW OF 2009 ACCOMPLISHMENTS**:
   - Ms. Bailey and Mr. Braswell emphasized accomplishments despite severe budget cuts. They thanked Commissioners for standing firm to work through difficult choices, even as more hard choices to maintain services loom.
   - Commission/Committee Co-Chairs reviewed the Commission's Vision, Mission and key 2009 accomplishments, outlined in a list of accomplishments included in the meeting packet.

7. **CO-CHAIRS' REPORT**:
   - The meeting theme was "Partnerships and Collaboration in the Future" facilitated by Donna Yutzy, Consultant.
   - The 2009 Consumer Caucus awards for outstanding service and commitment to improving the lives of Los Angeles County residents living with HIV went to Mark Davis for his contributions to HIV Oral Health services and Maxine Franklin for her 18 years of County service, most recently as Chief, Clinical Enhancement Services Division, OAPP, and continuing volunteer service to patients. Ms. Franklin will be working to educate mega-churches in SPA 6 on HIV.

   A. **Notification of Co-Chair Nominations**: Nominations for Ms. Bailey's Co-Chair seat were opened and Ms. Bailey re-nominated. The seat requires one-year Commission membership with preferred representation by the Co-Chairs for people of color, women and PWH. Both current Co-Chairs are PWH. Nominations will be accepted until the December election.

   B. **Member Nominations**:
   MOTION #2: Nominate Tonya Washington-Hendricks to the SPA 6 Provider seat, Dean Page to the SPA 3 Consumer seat and Whitney Engeran-Cordova to the District 4 Board representative seat and forward to the Board of Supervisors for appointment ***(Passed by Consensus)***.

   C. **Oral Health Services**: The Program/Planning News on "LA County's Response to the Need for HIV Oral Health Care Services" was in the packet. It details providers and services. A Spanish-language version will be available shortly.

8. **COMMISSION VISION AND MISSION**: There was no additional discussion.

9. **FUTURE OF HIV IN HEALTH**:
   A. **Ryan White Treatment Extension Act**:
      - Mr. Engeran-Cordova's presentation is based on the presentation from William McCall, AIDS Action Council, and Carl Schmid, The AIDS Institute, at the 10/30/2009 United States Conference on AIDS.
      - More than 300 organizations, including the Commission and OAPP, signed a community consensus document that advocated a three-year Ryan White extension with continued protection for states migrating from code- to name-based surveillance, TGAs, hold harmless and other items similar to the previous Act.
      - The Obama Administration supported four-year extension with modification of penalties for unobligated funds, elimination of distinction between EMAs and TGAs, time for states migrating from code- to name-based surveillance and stipends for training-selected AETC participants.
      - The four-year bill signed 10/30/2009 repeals the sunset prevision, increases unobligated funds threshold from 2% to 5%, authorizes 5% annual funding increases, eliminates the Severity of Need Index (SONI), protects code-based surveillance for three years, protects hold harmless while reducing it to 92.5% in FY 2012 and maintains 2009 TGAs for three years.

- Minority AIDS Initiative (MAI) grants are returned to formula awards based on disproportionately affected populations and synchronized with grant cycles for the other Parts. A GAO report is required.
- Planning councils are required to identify, diagnose and bring into care those not aware of their status, including timetables and barrier reductions. One-third of EMA supplemental grant criteria are tied to this new requirement and states are required to establish comprehensive strategies to address it.
- An annual 5 million testing goal is set starting 1/1/2010 with annual reports to Congress starting 1/2011. The Health and Human Services Secretary must also report to Congress in one year on CDC HIV prevention programs' effectiveness.
- A section on Notification of Emergency Services Personnel for Possible Exposure to Infectious Diseases on "airborne" exposure was returned and changes liability limit for states, cities and personnel.
- Reauthorization discussion will begin in 2011 in the context of the National HIV/AIDS Strategy and health care reform.
- Mr. Broadus suggested County impact review of eliminating SONI and assurance that the testing push does not imply ineffective prevention programs. Ms. DeAugustine noted Long Beach lost 60%+ of prevention funding.
- Mr. Engeran-Cordova thanked those who worked on reauthorization especially Mr. Pérez and Mr. Baker, OAPP, and Ms. Watt, P&P Co-Chair and UCHAPS. Work both here and in Washington, DC positively impacted reauthorization.

B. **Health Care Reform**:

- Ms. Cross, Health and Disability Consultant, noted only 17% of PWH have private insurance. Public insurance programs, however, have gaps, especially for the disabled who do not meet income eligibility requirements.
- Health care reform seeks to help some uninsured access Medicaid and others to access private insurance.
- The House passed a bill 11/7/2009. Senate bills are in Budget Office review with a final bill expected by Christmas.
- Key areas of debate: regulating sale of insurance; increasing low-income Medicaid; requiring individuals or companies to buy insurance; establishing insurance exchanges; subsidizing insurance purchase; changing Medicare to help retirees and disabled; as well as spurring innovation, promoting prevention and addressing racial/ethnic disparities.
- A key debate is whether to have a public option compete with private offerings. This was not done for Medicare Part D. While initially Part D private offerings were abundant, by the second year they had decreased in number and coverage.
- The three current bills are the just-passed House Leadership bill and two Senate bills pending merger: Finance Committee and Health, Education, Labor and Pensions (HELP) Committee bills.
- All require insurance, so the pool is not just the sickest. Finance covers most citizens/legal residents. HELP and House bills cover individuals and companies, except small businesses. Exchanges are state-based in Finance and HELP, but national for equity across states in the House. Public option: Finance, none; HELP, state-based; House, national.
- Regarding access, all three ban exclusion for pre-existing conditions and mandate benefit packages for exchange plans. HELP and House prohibit lifetime caps while Finance prohibits them for individuals and small companies.
- There will be out-of-pocket costs like co-pays, based solely on percentage of annual income. They will be capped with subsidies of 133% (Finance and House) or 150% (HELP) to 400% Federal Poverty Level (FPL) for other costs.
- Bills expand Medicaid (Medi-Cal) from disability-/age-related eligibility to income-based at 133% (Finance) or 150% FPL (HELP and House). The Finance bill also offers an option of an insurance subsidy for those at 100% to 133% FPL.
- Early Treatment of HIV Act (ETHA) is included as a bridge to implementation for the low-income by the House bill.
- Some fixes are proposed for Medicare. The Finance bill would discount drugs by 50% for those in the "donut hole" while the House bill would eliminate it by 2019. Both count ADAP contributions toward TrOOP.
- Bills include a 5-year Medicaid wait for legal immigrants. They are eligible for insurance subsidies, but undocumented are not and are barred from Medicaid entirely by the Finance bill.
- In other HIV-specific issues, at-risk population testing is addressed in the HELP and House bills. Integration of Ryan White providers is also required for exchanges in those bills.
- Comparative Effectiveness Research (CER) is mandated in some form in all bills. Debate continues on whether CER should address only clinical issues or system issues as well. The Federal Coordinating Council for CER recommended restricting stimulus funds to clinical in June 2009, but HRSA and the Commission are advocating for systems research.
- The "Medical Home" concept is also addressed in some way by all bills. It corresponds to Medical Care Coordination.

C. **AIDS Drug Assistance Program (ADAP)**:

- Ms. Cross said ADAP assists the un-/under-insured earning less than 400% FPL ($43,000) or up to $50,000 with a co-pay to provide full coverage, fill gaps in private or public insurance, or provide a bridge to other coverage like Medi-Cal.
- OA contracts with a Pharmacy Benefits Manager (PBM), currently Ramsell Corporation, which then contracts with the 3,500+ community pharmacies in the ADAP network to provide the approximately 200 medications on the formulary.
- OA has developed a community-based enrollment network of about 245 clinic, service organizations and jail sites, staffed by about 400 annually trained and PBM-certified ADAP enrollment workers.

- ADAP systems can be set up as direct purchase in which the state buys and distributes drugs via mail or approved pharmacies. California uses a rebate system in which the State receives a manufacturers' rebate negotiated nationally by the Fair Pricing Coalition on dispensed drugs, plus about $85 million in Ryan White Part B funds and State funds.
- $25 million was cut from ADAP for FY 2009-2010, but backfilled with the now mostly drained Drug Rebate Fund. For that reason, a statewide ADAP Summit was held 11/10/2009 to begin analysis and advocacy early in the budget process.
- The current estimate is for a deficit of $50-$100 million in FY 2010-2011, not including any additional cuts.
- California ADAP currently serves about 35,000 clients, but is expected to exceed 40,000 within two years. Of those, about 75% have incomes below 200% FPL. Over 61% rely on ADAP alone, while over 21% also have Medicare, and over 15% have private insurance. Los Angeles County has 41% of clients with San Francisco the next largest at 13%.
- The State is reviewing options to close the anticipated budget gap including removing about 120 drugs (all but ARVs) from the formulary, reducing eligibility to 200% FPL, adding cost-sharing below 200% FPL, and shifting financial drug responsibility from ADAP to municipalities for the 36 municipal jail systems now covered by ADAP.
- There was agreement at the Summit to: initiate community education and mobilization; push the State for better cost and pricing information; and increase State and local planning.
- Among the primary options discussed were: Federal assistance; administrative/PBM savings; increase rebates and/or review direct purchase; identify loans/bridge funding; Part A/B contributions; expand CARE/HIPP; review health care reform benefits; reform ADAP reimbursement; increase eligibility verification; use VA pricing systems; limit Medicare Part D plan choices. Current cost containment strategies were not considered acceptable.

11. **LOCAL COLLABORATIONS**:

A. **State Office of AIDS (OA)**:

- Dr. Roland, Director, OA, reported that one major goal for FY 2010 is to maximize local area funds. OA positions were cut 27%, including 33%+ in the Care Branch and 33% in the Administration Section to free funds.
- The second key goal is to maximize local decision-making. OA moved to a Single Allocation Model (SAM) that prioritizes outpatient ambulatory care and enables local decision-making on all other HRSA-approved service categories.
- Local health jurisdiction budgets, master agreements and program guidance are being finalized now.
- HRSA supplemental funds were received. They will aid local health jurisdictions and reimburse post-7/1/2009 expenses for some providers with discontinued contracts. MAI has also been received and is being distributed based on epidemiological trends.
- OA is seeking comprehensive planning rather than the quick decisions in FY 2010. Planning needs to include the uncertainty of supplemental funds and the MAI change to formula-based funding.
- ADAP funding is uncertain; the first public indication will be in the 1/10/2010 Governor's budget.
- Dr. Roland urged communication to the right venue. OA distributes, but does not budget, funds. A website is being developed for better community communication. It is best now to contact her or Clarissa Poole-Sims by email.

B. **Other County Departments**:

- Ms. Marchus, HIV Program Coordinator, Department of Mental Health (DMH), reported four HIV Program sites: Harbor-UCLA, Long Beach, Hollywood, and Compton providing comprehensive services with multi-disciplinary teams.
- Programs treat PWH and "at risk," e.g., MSM and women IDUs, or in relationships with men on the "down low".
- The DMH target population is the seriously mentally ill. Usual intake for PWH is 2-3 weeks; non-HIV is 4-6 weeks.
- Due to funding limits, DMH is collaborating with other agencies to develop services in other areas of the County.
- 150-200 PWH/at risk clients receive services with 8,000-10,000 per clinic moving between DMH and APLA, Van Ness and other providers as needed. High level meetings would help develop an improved countywide collaborative plan key to addressing budget cuts. The current focus is on integration with substance abuse programs.
- Team clinicians coordinate housing with assistance from a benefits specialist and/or medical case worker as needed.

C. **LA City Coordinator's Office**: This item was postponed to the 12/10/2009 Commission meeting.

D. **Prevention Planning Committee (PPC)**:

- AJ King, Co-Chair, PPC, reported their major task is to create a Comprehensive HIV Prevention Plan for the County. The current 2009-2013 Plan is a hybrid which prioritizes populations by both identities (e.g., MSM) and behavioral risk.
- The 2nd Annual Data Summit is planned for the Fall 2010 and an HIV Counseling/Testing Summit for 1/22/2010.
- A Program Collaboration and Services Integration (PCSI) Thank Tank is being developed to enhance HIV prevention collaboration with other areas like STD, Hepatitis, TB, mental health, substance use/abuse, youth, incarcerated.
- The PPC is also reviewing cost effectiveness methods to improve prevention measurement so it can be properly valued.

- Collaboration with the Commission continues on several fronts, e.g., the Latino Task Force is jointly chaired with Mr. Aviña, Commission, and Mr. Martinez, PPC, and is developing recommendations for Latino standards of care.
- An Integration Task Force is working to identify areas of the Care and Prevention Plans that might be integrated as well as mutually beneficial cross-training opportunities, such as the recently approved PPC transgender recommendations.
- Commission and PPC Co-Chairs continue to meet with joint body meetings planned. The PPC hopes to work with the Commission to define prevention as part of the prevention/care/treatment continuum of care.
- ➲ PPC input to the Strategic Planning Process for Medical Care Coordination (MCC) referred to MCC Transition Team.

E. **Health Districts**: This item was postponed to the 12/10/2009 Commission meeting.

F. **HOPWA**:
- Mr. Doan, HOPWA Coordinator, City of Los Angeles, noted one well-known program, Tenant-Based Rental Assistance Certificate (TBRAC), is operated by four housing authorities: the County of Los Angeles and the cities of Los Angeles, Long Beach and Pasadena. There can be delays when leasing programs open and large numbers apply at once.
- Another is the Short-Term Rent, Mortgage and Utilities (STRMU) which offers 21 weeks of rental assistance per year.
- HOPWA funds 36 contractors for supportive services like food, legal, housing case management, emergency shelter and transitional housing. Homeless-targeted programs are Emergency Housing and Meal Vouchers via local vendors.
- A Permanent Housing Placement Grant pays for a security deposit, first month's rent and the cost to turn on utilities.
- HOPWA is working to further collaboration: "Getting to Know Your Neighbor," California Endowment, 1/8/2010, will replace the annual case management conference, adding other County and Ryan White providers such as benefits specialists.
- There will also be DMH site open houses at the end of 2009 and beginning of 2010 to help build relationships.
- Mr. Doan stressed priorities planning between the Commission/OAPP and HOPWA leadership. A new client system will offer Federal demographics data and track clients to better identify client readiness for permanent housing.
- HOPWA staff is encouraged to participate in Commission training, e.g., the recent training on Benefits Specialty. Staff also looks forward to presenting on HOPWA programs to the Commission.
- Mr. Chud asked about affordable housing development. Mr. Doan said a percentage of HOPWA funds support that and the City Housing Department has dedicated resources to it. Check www.chirpla.org for availability information.
- HOPWA plans go to the Federal government. Major plans are open for public comment. Annual investment stays about $11 million. Eligibility guidelines can be revised annually as they just were. There is no lifetime HOPWA cap.

13. PRIMARY LOCAL PARTNERSHIP:

A. **OAPP Roles and Responsibilities**:
- Mr. Pérez, Director, OAPP, emphasized that OAPP is eager to work with the Commission as its Public Health partner to develop long-term, sustainable programs that ensure all PWH have the best chance to thrive.
- OAPP manages Part A resources from HRSA with the Commission as well as Part B resources which come into the County through the State. Some providers also receive Part C resources directly which might well be better leveraged.
- HRSA requires the Planning Council (Commission) and Grantee (CEO/OAPP) to work together jointly:
  - ***CEO***: Commission formation and membership;
  - ***Commission***: Priority-setting, directives, resource allocation, Assessment of the Administrative Mechanism (AAM);
  - ***OAPP***: Procurement, contract monitoring;
  - ***Joint***: Needs assessment, comprehensive planning, coordination of services, clinical quality management (OAPP)/standards of care (Commission), cost effectiveness/outcomes evaluation.
- OAPP administrative duties are: ensure funds are used fairly and appropriately; ensure Ryan White (RW) is funding of last resort; establish intergovernmental agreements as needed; distribute funds per Commission priorities/allocations; establish funding-related grievance procedures; ensure service delivery to women, infants, children and youth; ensure service availability/accessibility to eligible clients; ensure quality services through clinical quality management; prepare/submit Part A application; limit grantee/provider administrative costs; monitor contracts.
- OAPP planning duties are: provide Commission information/advice for fund allocation, support Commission members.
- Commission/OAPP shared duties are: needs assessment, comprehensive care plan, coordinate with RW programs and other services such as prevention and substance abuse, including via the Statewide Coordinated Statement of Need (SCSN) to maximize funds, reallocate funds to fully expend grants, minimum standards of care, service effectiveness.
- Mr. Pérez said it is key in times of economic contraction to manage both monetary and human resources wisely to meet legislative requirements, i.e., how can planning activities be streamlined while improving planning itself.
- Service effectiveness supports planning with cost factors to establish efficiency, identifying and addressing unmet need, and identifying an effective and affordable service mix for the County's 14,500 PWH who rely on RW.

B. **Commission Roles and Responsibilities**:

- Mr. Vincent-Jones, Executive Director, Commission, agreed with Mr. Pérez on providing the best services effectively.
- RW legislation outlines planning council, grantee and other stakeholder duties well and in a generally complimentary manner. It is designed to force local jurisdictions to build a collaborative partnership including some creative tension.
- Jonathan Freedman, Director, Public Health recommended dividing responsibilities into, which have been further defined by Commission staff:
  - ***Must Do***: Required and could adversely affect local HIV resources if not done;
  - ***Need To Do***: Should be done though not required, strongly encouraged if cost negligible;
  - ***Should Do***: Would enhance Continuum of Care.
- Mr. Vincent-Jones recommended continuing "Must Do' and "Need To Do" activities, but restricting "Should Do" activities to those that can be funded with alternate resources if and when they can be obtained.
- The Commission has roles as a RW Part A Planning Council (PC) and as a County-chartered Commission – uncommon for PCs. Authority derives from RW program legislation, HRSA requirements and guidance, and County Code 3.29.
- HRSA guidance requires PCs to: establish smooth PC operations, assess EMA HIV/AIDS service needs, prioritize allocation of funds, develop a comprehensive plan, and assess efficiency of the administrative agency (AAM).
- HRSA also expresses PC expectations through the training manual and, e.g., Project Officer direction such as: maintain full/meaningful PWH/A participation, recruit and train members, develop grievance procedures, manage conflict of interest, and conduct evaluation activities. These are often shared responsibilities. How to share such responsibilities varies from specific HRSA direction to HRSA allowing jurisdictions to determine their own arrangements.
- The Commission contributes some entire pieces to the Part A application, contributes to others and develops the MAI Plan. PCs provide an annual letter of concurrence with HRSA-mandated membership requirements, comprehensive training and allocation compliance. A PC letter of endorsement that funds have been expended in accord with priorities and allocations is an annual Condition of Award (COA). The triennial Comprehensive Care Plan can also be a COA.
- The County Code generally is consistent with RW, but expands Commission responsibilities to: study, advise and recommend to the Board of Supervisors and Grantee on matters related to HIV/AIDS; make reports; act as a Planning Council; make recommendations for all HIV/AIDS programs locally; make recommendations concerning allocations and funds other than Parts A and B (for which allocations are directed rather than recommended).
- Mr. Vincent-Jones reviewed responsibilities by Commission body and Mr. Freedman's priorities as follows:
  - ***Must Do***:
    - Commission: Public meeting/decision-making, unmet need, ensure services of last resort, secure other funding;
    - Priorities and Planning (P&P) Committee: Comprehensive Care Plan (triennial COA), Needs Assessment, Priority- and Allocation-Setting (P&A), MAI, financial expenditures review, HIV Unaware/Counseling and Testing integration into RW Continuum of Care (new);
    - Operations Committee: AAM (assesses entire administrative system in distributing funds per priorities and allocations), PWH/A participation, planning body operations/membership services, open nominations process, comprehensive training (addressed in letter of concurrence to RW);
    - Standards of Care (SOC) Committee: Standards of Care (HRSA guidance states, e.g., "Adherence to quality management expectations requires measurement of the quality of services delivered, the degree to which those services meet or exceed established professional standards." Also, "Standards of Care provide a more substantive and reliable measure of service quality than client satisfaction alone,") Continuum of Care, Grievance Policy/Procedures (on Continuum of Care, delivery of service categories or P&A);
    - Joint Public Policy (JPP) Committee: Policy development/implementation (especially on securing other resources, ensuring services are last resort, unmet need and needs of the underserved), benefits specialty (also key in accessing other sources of funding to ensure RW is used as funding of last resort).
  - ***Need To Do***:
    - Commission: special populations, directives, coordination of services;
    - SOC Committee: Evaluation of Service Effectiveness (ESE: PC must use outcome and cost effectiveness data for P&A and Comprehensive Care Plan. Commission is using existing data from non-provider, macro level.)
  - ***Should Do***:
    - Commission: Research/analysis activities;
    - Operations Committee: Public awareness;
    - SOC Committee: Evaluation (AAM and ESE meet need), Comparative Effectiveness/Best Practices.
- Mr. Vincent-Jones believes these also meet Mr. Freedman's recommendation to review activities in hard economic times by how they address funding, services and engaging people in care. Planning is critical to ensure best possible choices.

C. **Implementation of Roles/Responsibilities in Economically Uncertain Times**:

- Per the meeting's theme, "Partnerships and Collaboration in the Future," all valued the broadest range of HIV and related partnerships, e.g., housing, TB, Hepatitis, substance abuse, undocumented immigrants, incarcerated/post-incarcerated populations and especially STD (where 5% of those with syphilis clients cause up to 50% of new infections).
- Several emphasized consumer education and mobilization as key to help consumers access needed services and protect services. Ms. Forrest noted collaboration can include non-monetary individual efforts, such as time banks and bartering.
- Mr. O'Brien suggested improved coordination of Commission planning with OAPP procurement.
- Mr. Simon, AIDS Coordinator, City of Los Angeles, said the City stands ready to leverage policy and political resources.
- Mr. Pérez noted that Mr. Freedman periodically facilitates meetings, such as the recent one on 11/6/2009 with Commission and P&P Co-Chairs, Mr. Vincent-Jones, Dr. Green, Mr. Baker and himself on issues including the MOU and comments at the last Commission meeting. There was a report there on an OAPP review of things OAPP must do, things it does but cannot sustain, and things it does not do but should. The situation is expected to worsen with 33 staff reductions imminent.
- OAPP tries to balance: 1) consumer needs such as those expressed at "HIV Services Round Tables"; 2) provider realities as they are asked to do more yet faced a wave of fiscal contractions about a year ago resulting in staff reductions, a second wave this summer, and more on the horizon; 3) Commission expectations for standards of care; and 4) financial realities.
- He felt the gap growing, as noted at the 10/8/2009 Commission meeting, between standards service expectations and provider realities. The Therapeutic Monitoring Program (TMP) expectation, e.g., is four viral loads per client per year. National standards call for two, three if the client is unstable and four if in distress. The higher standard cannot be met with County TMP investment reduced from $3.7 to about $2 million for 14,500 clients with 1,700 new clients per year.
- Treatment Education and Medical Nutrition Therapy are defunded with medical providers asked to do an annual nutrition assessment. If ADAP is flat-funded ($80 million), the County gap for its 41% of clients will be $32 million.
- Mr. Pérez complimented Commission work in developing a full compliment of standards. He questioned, however, the viability of continuing to develop standards without regard to finances as has been the model.
- On ESE, Mr. O'Brien led a Medical Outpatient (MO) provider effort to identify 29 indicators for the upcoming MO $20 million RFP. Mr. Pérez felt Commission effort would be best focused on systemic effectiveness rather than replicating indicators. The OAPP Medical Advisory Committee of 18 medical directors could also guide the MO standard.
- In a recent survey, OAPP chiefs spent on average 182 hours monthly on Commission requests and related activities. Mr. Pérez found that excessive in lieu of MO, Oral Health, Benefits Specialty and fiscal work.
- Mr. Pérez noted Peter Kearns, Director, STD Programs, recently called for help in saving nucleic acid application testing. The County has sites at AHF and GLC for this advanced testing that identifies 1 of 250 negative tests as HIV+. He also asked for help with syphilis elimination and partner services. Mr. Pérez had to tell him to choose one.
- Mr. Pérez said the Commission excels beyond most other planning groups even if only its core duties were considered. The key concern now is to focus Commission and OAPP work on what best serves consumer needs on the ground.
- Mr. Land noted standards are living documents. Improved Commission/OAPP communication can address issues. Going forward, Medical Care Coordination (MCC) will improve efficiency albeit with the loss of less viable providers.
- Mr. Vincent-Jones agreed with others that core issues are trust, respect and communication. At the same time, he questioned concern over standards as they were based on existing contracts and Public Health Service guidelines. Medical Nutrition was pulled back for review of the concern raised. ESE uses existing data for systemic review. Yet, despite those discussions, communication does not seem effective as the same questions are raised repeatedly.
- Several noted 182 hours should not be a focus but, rather, whether Commission-related OAPP time was well spent.
- Mr. Braswell emphasized the Commission and OAPP can and have worked together effectively in many areas such as policy and budget advocacy, but communication needs improvement. Maintaining standards, even if they cannot be fully implemented now, serves as a benchmark that can benefit services in future as the health landscape changes.
- Ms. Palmeros said, as a provider, changes in eligibility and service access can help. Sometimes a standard may act as a goal even as the provider compromises on some aspects temporarily to best serve the client's care needs.
- Mr. Broadus advocated a business-oriented, cost- and human value-effective approach to sustain, enhance and manage the comprehensive public health system as it relates to HIV/AIDS, including prevention using Mr. Freedman's principles.
- Mr. Pérez committed to improved communication as his first goal. He felt planning should now focus on the most imminent needs in the next 30-, 90-, 100- and 210-days to address critical issues like ADAP.
- Mr. Vincent-Jones pledged to clarify assumptions and miscommunications on the spot and asked all to join him. He added the work done on ESE can help guide cost-effective planning.
- It was agreed differing undefined role interpretations has led to miscommunication and disagreements that are especially disruptive in this economic contraction. Concrete steps to improve communication and resolve differences taken were:

1. Commission and OAPP will address miscommunication and disagreements promptly and respectfully.
2. OAPP has assigned specific management staff to each Committee to ensure better communication.
3. The Commission will make more extensive use of its assignment system to clarify committee actions.
4. The MOU Subcommittee will address differing perspectives on this document meant to memorialize how the Commission and OAPP interact.
5. SOC will develop a standards cycle, a trigger system for standard review outside the cycle and effective threshold funding levels. The Medical Advisory Committee will act as Medical Outpatient Services expert review panel.

MOTION #3: ***(Broadus/Orozco)***: Adopt the lens of "Must Do, Need to Do and Should Do" to guide planning and refer to the Priorities and Planning Committee to develop recommendations for the 12/10/2009 Commission meeting ***(Passed by Consensus)***.

15. **NEXT STEPS**: There was no additional discussion.

16. **ANNOUNCEMENTS**: There were no announcements.

17. **ADJOURNMENT**: Mr. Braswell adjourned in memory of Bradford Bowen, Mark Etzel and Howard Jacobs at 5:00 pm.

A. Roll Call (**Present)**: Aviña, Ballesteros, Braswell, Broadus, Chud, DeAugustine, Engeran-Cordova, Frye, Giugni, Land, Liso, Long, O'Malley, Orozco, Pérez, Peterson, Sayles, Simon, Sotomayor

MOTION AND VOTING SUMMARY

MOTION #1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION #2: Nominate Tonya Washington-Hendricks to the SPA 6 Provider seat, Dean Page to the SPA 3 Consumer seat and Whitney Engeran-Cordova to the District 4 Board representative seat, and forward to the Board of Supervisors for appointment.	***Passed by Consensus***	**MOTION PASSED**
MOTION #3 ***(Broadus/Orozco)***: Adopt the lens of "Must Do, Need to Do and Should Do" to guide planning and refer to the Priorities and Planning Committee to develop recommendations for the 12/10/2009 Commission meeting.	***Passed by Consensus***	**MOTION PASSED**